

PATIENT INFORMATION

Last Name (Legal)		First Name, Middle Name (Legal)		Preferred Name	
Gender Identity <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female /Male to Female <input type="checkbox"/> Other/ Non-Binary <input type="checkbox"/> Male <input type="checkbox"/> Transgender Male / Female to Male <input type="checkbox"/> Prefer to decline		Preferred Pronouns <input type="checkbox"/> She/Her <input type="checkbox"/> He/Him <input type="checkbox"/> They/Them <input type="checkbox"/> Other_____		Sex assigned at birth <input type="checkbox"/> Female <input type="checkbox"/> Male	
SSN	Mailing Address		City	State	Zip Code
Phone	E-Mail		Would you like electronic access to your chart? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Marital Status	Race (Select all that apply) <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Decline		Ethnicity <input type="checkbox"/> Hispanic or Latino/a, Latinx <input type="checkbox"/> Not Hispanic, Latino/a, Latinx <input type="checkbox"/> Decline		Do you need an Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No
Preferred Language	Communication Assistance? <input type="checkbox"/> Hearing <input type="checkbox"/> Speech <input type="checkbox"/> Vision <input type="checkbox"/> Other: _____		Do you have a companion needing Hearing or Speech Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No		
May we leave a message for appointments or Normal lab values? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Care Provider <input type="checkbox"/> No Primary Care provider		Are you an Organ Donor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Emergency Contact Name		Emergency Contact Phone		Relationship to patient	
Do you have an Advanced directive? <input type="checkbox"/> Yes, it's located at: _____ <input type="checkbox"/> No Do you have a Living Will? <input type="checkbox"/> Yes, it's located at: _____ <input type="checkbox"/> No					
Do you have a Medical Power of Attorney? <input type="checkbox"/> Yes, it's located at _____ <input type="checkbox"/> No					

RESPONSIBLE PARTY (If different from patient i.e.; Parent, Legal Guardian/Healthcare Durable Power of Attorney)

Last Name (Legal)		First Name, Middle Name (Legal)		Date of Birth	
Mailing Address (if different)			City	State	Zip Code
Phone	SSN	Relationship to Patient	Marital status:	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> X	

INSURANCE/CLAIM INFORMATION

Worker's Comp Claim? <input type="checkbox"/> Yes, date of injury _____ Body Part Injured _____ Claim Number _____					
Motor Vehicle Accident? Date of Injury _____ Auto Insurance Carrier _____ Claim/Policy Number _____					
Primary Insurance Name		Subscriber Name		Subscriber ID Number	
Date of Birth	SSN	Phone Number	Same Address? <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to Patient	
Employer Name		Subscriber Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Student <input type="checkbox"/> Active Military <input type="checkbox"/> Disabled <input type="checkbox"/> Retired			
Secondary Insurance Name		Subscriber Name		Subscriber ID Number	
Date of Birth	SSN	Phone Number	Same Address? <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to Patient	
Employer Name		Subscriber Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Student <input type="checkbox"/> Active Military <input type="checkbox"/> Disabled <input type="checkbox"/> Retired			

MEDICARE RECIPIENTS

Are you receiving benefits from any of the following programs: <input type="checkbox"/> Black Lung <input type="checkbox"/> Veterans Affairs <input type="checkbox"/> Disability <input type="checkbox"/> Government Research <input type="checkbox"/> Kidney Dialysis or Transplant <input type="checkbox"/> ESRD If Yes to any above programs, date benefits began: _____	
Are you or your spouse employed? <input type="checkbox"/> Self <input type="checkbox"/> Spouse If no, year of retirement: <input type="checkbox"/> Self _____ <input type="checkbox"/> Spouse _____ If employed, do you or your spouse have group health plan coverage from current employment? Self <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No	Does the employer that sponsors your Group Health plan employ 20 employees or more? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the employer that sponsors your spouse's Group Health plan employ 20 employees or more? <input type="checkbox"/> Yes <input type="checkbox"/> No

SNOQUALMIE VALLEY HOSPITAL

General Consent for Admission and Treatment

Consent for Medical Treatment: I, the undersigned, hereby consent to and permit my attending physician and his/her designees, Snoqualmie Valley Hospital and its employees, and all other persons caring for me to provide treatment and care as deemed medically necessary or advisable and available to me during inpatient, outpatient, or office visit. This may include routine examinations, diagnostic tests (including radiology and laboratory), injections, and other hospital procedures and therapies. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me as to the result of treatment or examination. I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing me an opportunity to give informed consent for that procedure. Informed consent means the medical provider must disclose information to me including expected benefits and risks of a particular procedure and/or treatment.

Release of Confidential Information: I authorize Snoqualmie Valley Hospital and/or the attending physician/provider to release any information from my medical record necessary to facilitate health care claims processing and payments. This release may include specific information related to the testing, diagnosis and/or treatment of sexually transmitted diseases (including HIV), alcohol or drug abuse, and mental health/psychiatric disorders. I also consent to the release of any information as needed for post-discharge care or transfer of care to other health care facilities or agencies or as required by law. In the event a healthcare worker is exposed to my blood or body fluid in a manner that may pose a risk for transmission of a blood-borne infection during this hospitalization, office visit, or outpatient procedure, I am giving consent to be tested for blood-borne pathogens, at no cost to me, so the healthcare worker can be promptly treated. I authorize release of these test results to the exposed health worker and his/her healthcare provider.

Consent to Photograph: The taking, reproduction and use of photographs for the purpose of documentation of findings in connection with my diagnosis, care, and treatment at Snoqualmie Valley Hospital District is approved. Photographs and digital imaging are considered a part of the medical record and afforded the same protections as all other Protected Health Information.

Receipt of Electronic Mail: I acknowledge that providing my email authorizes solely Snoqualmie Valley Hospital to send me patient care announcements and patient care surveys (administered by our vendor); my information will not be sold or disclosed to any other third party.

Patient Personal Property: I am aware that Snoqualmie Valley Hospital is not liable for lost or damage of any personal property unless placed in a safe.

Notice to Outpatients: Your authorization for outpatient services is required once per calendar year.

Assignment of Insurance Benefits: I authorize my insurance benefits be paid directly to the provider of services. If my insurance plan requires copay for services received, I agree to pay the copay at the time of service. I understand that I am responsible for charges not covered by my insurance company; I understand it is my responsibility to meet the contract requirements of my health plan, and I agree to be personally responsible for this account. If payment on this account becomes delinquent, I agree to pay any interest and collection fee(s) which may accrue.

Medicare Patients: I certify the information I have provided in connection with my application under Title XVIII of the Social Security Act is correct. I request that payment for any authorized Medicare benefit be made on my behalf be made to the hospital or its employed physicians. I authorize any holder of medical information or other information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine my entitlement to these Medicare benefits or benefits for related services.

Self-Pay Financial Agreement: If I am currently not covered by an insurance plan, I will be personally responsible for payment. I understand if my income is within 100%-300% of Federal Poverty Guidelines, I may be eligible for a discount on services. A copy of the full payment policy or financial aid policy is available upon request at the reception desk. The full Financial Aid policy and application are also available on our website: <https://snoqualmiehospital.org>. For more information on understanding your bill, setting up a payment plan, financial aid, or applying for Medicaid, please contact our billing office at 425-831-2310.

Patient Certifications: I acknowledge receipt of the following informational pamphlets; Patient Rights and Responsibilities, Notice of Privacy Practices, and Advance Directives (Inpatient only).

I attempted to obtain acknowledgment but the patient declined to sign. Employee signature: _____

I CERTIFY THAT I HAVE READ THE FOREGOING AND THAT I UNDERSTAND ITS CONTENT. MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I CONSENT TO TREATMENT AT SNOQUALMIE VALLEY HOSPITAL DISTRICT.

Patient Signature or Authorized Representative

Date

Printed name if signed on behalf of the patient

Relationship